DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 6

2. STATE: WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1924 OF THE ACT, 435.725

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 114,432
b. FFY 02 $ 228,865

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 2.6-A, PAGE 4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME

10. SUBJECT OF AMENDMENT:
PERSONAL NEEDS ALLOWANCE (PNA)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Garry L. McKee Iris Oleske

13. TYPED NAME:
GARRY L. MCKEE, PH.D., M.P.H. IRIS OLESKE

14. TITLE:
DIRECTOR STATE MEDICAID AGENT

15. DATE SUBMITTED:

16. RETURN TO:
IRIS OLESKE
STATE MEDICAID AGENT
WYOMING DEPARTMENT OF HEALTH
OFFICE OF MEDICAID
147 HATHAWAY BUILDING
CHEYENNE WY 82002

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 29, 2001

18. DATE APPROVED:
7/31/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: June 28, 2001

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Wyoming

Citation(s)		Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2.	The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples for All Institutionalized Persons. a. Aged, blind, disabled: Individuals $50.00 Couples $100.00 For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $30.00 Adults $30.00 For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the bases or formula for determing the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A. $30.00